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SPECIAL ISSUE – EDITORIAL

Jules Angst

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A seriously underestimated health burden

According to WHO projections by the year 2020 depression will rank as second only to ischaemic heart disease in the global disease burden. To help reduce that burden its exact nature must be clear. Very probably at least half the diagnoses of depression are in fact hidden bipolar II disorders, a condition seriously underdiagnosed. There is good reason, for example, to doubt that epidemiological studies based on single lay interviews and designed without follow-up are able to identify lifetime mild mania in subjects suffering from major depressive episodes. In a 30-year follow-up of hospitalised patients, there was a diagnostic conversion from depressive into bipolar illness in over 50 % of subjects (Angst et al. JAD in press). These findings accord with the outcome of a 20-year long prospective community study, in which about half of all mood disorders turned out to be bipolar disorders, and are compatible with the results of modern clinical studies, as recently reviewed by Akiskal (2002). There is reason then for considering that most of the literature on major depression may be dealing with heterogeneous samples that include large numbers of undiagnosed bipolar II patients.

A revision of the diagnostic criteria for hypomania is necessary

There is arguably no operational diagnosis in adult psychiatry as controversial as hypomania. For the purposes of research and treatment in the field of affective disorders the definition of hypomania is the core problem: it determines whether and how may major depressive episodes are to be considered as bipolar II disorders. The current definition is biased towards disturbance of mood; the modern term "mood disorders" is too narrow and has led to the mandatory criterion A for a diagnosis requiring only a mood change and neglecting hypomania's core features of overactivity, as stressed by a group of experts (Akiskal et al. 2001) and shown by a community study (Angst et al. 2002).

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Consequences of a higher diagnostic sensitivity to bipolar disorder

If it is indeed true that half of all depressives are bipolars, most research findings in the field will need to be revised, and future treatment studies of depressed patients will have to take this large hidden group of bipolar II disorders into account. In addition, on the level of subdiagnostic "minor" mood disorders, we will need to get used to the fact that dysthymia, minor and recurrent brief depression can all manifest as unipolar or bipolar disorders.

Cognitive disturbances in affective disorders

An NIMH conference on the measurement of depression held in 2002 concluded that current depression rating scales were deficient and that, among other new aspects of depression, future instruments should include cognitive functioning items, such as decision-making, concentration and memory. Modern neuro-psychological research has provided unexpected new insights into cognitive functioning during both depressive and manic states. While the cognitive changes in depressive patients described by Aaron Beck are already well known, the cognitive impairments on tests of pattern and spatial recognition, memory and delayed visual recognition, which are common to both depression and mania – syndromes intuitively thought to be polar opposites – are most surprising (see reviews of Murphy and Sahakian 2001–66488; Roiser et al. 2003–67141). The paper

of Luke Clark and Guy M Goodwin from Oxford University gives a new comprehensive overview of the field with special emphasis on bipolar disorder. It presents experimental evidence of impaired target detection as an important relatively *specific* trait marker, independent of severity of mania and recovery and of sustained attention deficit as an *unspecific* marker of the course of bipolar disorder. Atypical antipsychotics have been reported to improve some of these cognitive deficiencies (MacQueen and Young (2003), Bipolar Disorder 5(Suppl. 2):53–61d). Modern cognitive research could soon provide promising new correlates for biological research on mood disorders and their neurotransmitter functions.

Mixed states in bipolar disorder and schizo-affective disorders

The simultaneous measurement of manic and depressive symptoms has convincingly demonstrated the frequency of mixed states. Kraepelin made a clear distinction between mixed states occurring as short transitional states of remission, and episodes which manifest as mixed states. Kraepelin considered the former to be more common. Mixed episodes have been shown to be more refractory to therapy and prophylaxis than pure manic and schizo-manic episodes.

Franco Benazzi's contribution, comparing bipolar II patients experiencing mixed states during major depressive episodes to those without those mixed states, did not find any difference between the two groups in terms of a previous history of cycling episodes. This finding does not support Kraepelin's view that most mixed states occur as a transitional state of a cycling episode. Benazzi also found that mixed state patients were more often women and more commonly characterised by atypical features and temperamental mood lability. This mood lability has recently been shown to be a risk factor for bipolar disorder (Angst et al. 2003), which is genetically independent of the positive family history of bipolar disorder and does therefore not just represent a mild manifestation of the bipolar spectrum.

Marneros et al.'s paper on a prospective longitudinal study is the first to demonstrate that mixed states also occur in schizoaffective disorders. Although mixed states were found in one fourth of bipolar and one third of schizobipolar patients, their study clearly shows that mixed episodes can occur at any time throughout the illness and are usually transient phenomena in the course of multiple episodes (less than 3 % of all episodes were mixed); thus, patients with recurrent mixed episodes are very rare and may not even form a special subtype of the disorder. Mixed episodes were found to be more common in bipolar women than men, a finding comparable to Benazzi's, but this gender difference was not found in mixed states in schizoaffective disorders. Compatible with other reports the study found a high rate of disability pensions among mixed-state patients.

Marneros et al.'s paper also indicates that the restrictive concept of schizoaffective disorders in DSM-IV and ICD-10, limiting the diagnosis to the concurrent and neglecting the sequential type, is not justified. Numerous papers have described a diagnostic change from depression/mania to schizophrenia and vice versa (review of Angst 1986–70998 in Marneros and Tsuang ed).

The concept of a broad mood or affective spectrum vs. a mood disorder dichotomy

The dichotomy of unipolar vs. bipolar disorders has been replaced by a more refined spectrum concept with multiple diagnostic subgroups. Our paper (Angst et al.) on the heterogeneity of bipolar I disorder deals with some of these subgroups on the level of major depressive and major manic episodes. It suggests that the views of Kleist, Neele and Leonhard on the existence of pure mania or mania with mild depression should be integrated and may help identify a clinically interesting subgroup with a relatively better prognosis compared to bipolar I disorder. Our findings thus question many drug trial protocols, which select patients solely on the basis of the presence of mania; these manic patient groups are probably heterogeneous and include monopolar manics, with a much lower recurrence risk and perhaps a different treatment response.

Psychotherapy of bipolar disorders

The very concise and comprehensive review by Maria Jose Gutierrez and Jan Scott demonstrates the wide range of psychosocial interventions available for treating bipolar disorders. Bipolar patients in need of a life-long stabilising medication also require lifelong psychological care in order to maintain compliance. Psychosocial interventions added to medication certainly have important positive effects on the number, length and severity of recurrences and can improve social functioning, productivity, well-being and partnership. Further research is needed to clarify some open questions about the effects of such treatment on depressive or manic symptoms and especially to specify the match between patient and psychosocial intervention. The type of intervention is still determined more by the skills or the programmes of the therapists than tailored to the patient's specific profile. Psychosocial interventions have a promising future and we hope that this type of treatment will become everyday good clinical practice.

In conclusion this special issue of the European Archives … on bipolar disorders is intended to stimulate new ways of thinking, departing from the current lines of research mainly based on the diagnostic and statistical manuals.